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No. 00-1021

# In the Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
*Petitioner*,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
*Respondents*.

**On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit**

## BRIEF OF THE STATES OF TEXAS, ARIZONA, CALIFORNIA, CONNECTICUT, DELAWARE, FLORIDA, HAWAII, INDIANA, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, OHIO, OKLAHOMA, PENNSYLVANIA, SOUTH CAROLINA, TENNESSEE, UTAH, VERMONT, VIRGINIA, WASHINGTON, WEST VIRGINIA, AND WYOMING, AND THE TERRITORY OF PUERTO RICO AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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## QUESTION PRESENTED

Whether Congress intended that the Employee Retirement Income Security Act of 1974 (ERISA) preempt state laws that provide for binding, independent review of an HMO's decision that the treatment recommended by a patient's treating physician is not medically necessary.

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**OTHER AUTHORITIES**

J. Scott Andresen, *Is Utilization Review the Practice of Medicine?, Implications for Managed Care Administrators*, 19 J. LEGAL MED. 431 (Sept. 1998) . . . . . 14

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## INTEREST OF THE *AMICI CURIAE*

The state *amici curiae*, through their Attorneys General, respectfully submit this brief in support of Respondents Moran and State of Illinois asking the Court to affirm the judgment of the Seventh Circuit. States have a vital interest in ensuring that the scope of preemption by the Employee Retirement Income Security Act of 1974 (ERISA) is not extended beyond Congress's intent. The text of ERISA and decisions of this Court evidence that Congress intended to reserve powers to the States. ERISA § 514(b)(2)(A) preserves the States's authority to regulate insurance and nothing in ERISA evidences an intent to displace the States's historical role to regulate healthcare. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 661 (1995).

The statute at issue in this case, § 4-10 of the Illinois HMO Act is one of forty state independent review statutes[1]

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[1] 215 ILL. COMP. STAT. 125/4-10; ALASKA STAT. § 21.07.050; ARIZ. REV. STAT. § 20-2537; CAL. [HEALTH & SAFETY] CODE § 1374.30; CAL. [INS.] CODE § 10169; COLO. REV. STAT. § 10-16-113.5; CONN. GEN. STAT. § 38a-478n; DEL.CODE tit. 16, § 9119; FL. STAT. §§ 641.51–641.511; GA. CODE § 33-20A-32; HI. REV. STAT. § 432E-6; IND. INS. CODE § 27-13-10.1-1; IOWA CODE § 514J; KAN. STAT. § 40-22a13; KY. ST. § 304.17A-623; LA. REV. STAT. § 22:3081; ME. REV. STAT. tit. 24-A § 4312; MD. CODE [INS.] § 15-10A-03; MASS. GEN LAWS ch. 1760, § 14; MICH. COMP. LAWS §§ 550.1901–1929; MINN. STAT. § 62Q.73; MO. REV. STAT. § 376.1385; MONT. CODE § 33-37-102; N.H. REV. STAT. 420-J:5; N.J. STAT. §§ 26:2S-11, 26:2S-12; N.M. ADM. CODE tit. 13, § 10.17.24; N.Y. [INS.] LAW § 4910; N.Y. [PUB. HEALTH] LAW § 4910; 2001 N.C. Sess. Laws 446 (S.B. 199); OHIO REV. CODE § 1751.84; OKLA. STAT. tit. 63, § 2528.3; OR. LEGIS. ch. 266; 40 PA. STAT. §

that provide some form of independent review of a health maintenance organization's (HMO) reversal of a treating physician's medical-necessity decision. These statutes are intended to improve the quality of care provided by HMOs.[2] Although the particulars of independent review differ from State to State, the laws all require an HMO to use an independent reviewer. *External Revire Update*, p.1. Differences among the States include the role of regulatory agencies, and whether the insured, the physician, or another individual may request the independent review. *Id.* But they all "serve as a safety valve" to correct mistakes or ill-advised decisions by HMOs. *Id.* This is all part of the States's traditional function of regulating healthcare and insurance. Rush Prudential's claim of a right to engage in medical decisionmaking without regard for state law cannot be squared with congressional intent, this Court's jurisprudence, and federalism concerns. The state *amici curiae* ask the Court to affirm the Seventh Circuit's judgment, which held that § 4-10 of the Illinois HMO Act is not preempted by ERISA.

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991.2162; R.I. GEN. LAWS § 23-17.12-10; S.C. CODE §§ 38-71-1910–2060; TENN. CODE § 56-32-227; TEX. INS. CODE art. 21.58A; UTAH CODE § 31A-22-629; VT. STAT. tit. 8, § 4089f; VA. CODE §§ 38.2-5900–5905; WASH. REV. CODE § 48.43.535; 2001 W. Va. Acts 166 (H.B. 2216) (to be codified at W. VA. CODE § 33-25C-6). The District of Columbia also has enacted an independent review statute. D.C. CODE § 32-571.7.

[2] Geraldine Dallek and Karen Pollitz, Institute for Health Care Research and Policy, Georgetown University, *External Review of Health Plan Decisions: An Update*, May 2000, p.1, <http://www.kff.org/content/archive/3020/review_r.pdf> (prepared for the Henry J. Kaiser Family Foundation) ("*External Review Update*").



## SUMMARY OF ARGUMENT

The circuit courts have often taken such an expansive view of ERISA's "relate to" preemption clause that "for all practical purposes pre-emption would never run its course." *Travelers*, 514 U.S. at 655. Consequently, this Court ruled that absent the express intent of Congress to preempt, traditional state powers can and should coexist with federal regulation. *Id.* at 661. Again, in 1997, the Court applied traditional preemption analysis, rather than relying on the enigma of ERISA's express preemption clause, to determine whether ERISA preempted state law. *Boggs v. Boggs*, 520 U.S. 833 (1997). The circuits, however, continue to employ myriad "relate to" tests and, as a result, ERISA preemption analysis is mired in a jurisprudential quagmire. This Court should clarify that ERISA's express preemption provision, including the "relate to" clause, is essentially a reference to traditional preemption jurisprudence.

Under traditional preemption principles, as well as the test for ERISA preemption enunciated in cases such as *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997), independent review statutes, like § 4-10, are not preempted by ERISA. This Court noted in *Pegram v. Herdrich*, 530 U.S. 211 (2000), that medical-necessity decisions are mixed-eligibility decisions consisting of aspects of both medicine and coverage, but reserved the question of what standards would govern a claim by a patient who was denied reimbursement for medical care. *Pegram*, 520 U.S. at 229 n.9 (citing 29 U.S.C. § 1132(a)(1)(B)). This case places that unresolved question squarely before this Court.

In order to answer that question, the Court must first determine whether the coverage aspect of a mixed-eligibility decision predominates over the medical aspect. The state *amici* believe the medical aspect must necessarily predominate in a medical-necessity decision, as the very terms imply. The question is one of medical necessity—a decision involving the exercise of medical judgment. Because regulation of the exercise of medical judgment is historically a matter of State concern, there must be some evidence that Congress intended to preempt the States's ability to regulate these decisions. The state *amici* maintain that there is no evidence of such congressional intent and thus independent review laws—the process the States have chosen to regulate these medical-necessity decisions—are not preempted by ERISA.

Even if, on the other hand, the Court concludes the coverage aspect of a medical-necessity decision predominates, then independent review laws are nevertheless not preempted for two reasons. First, independent review laws do not impinge on plan administration in a way that requires preemption because medical-necessity decisions are necessarily unique, fact-specific decisions involving medical judgment, rather than uniform coverage decisions involving interpretation of plan documents. Second, if medical-necessity decisions are construed as coverage decisions, then they should be considered insurance coverage decisions, and Congress expressly partitioned the power to regulate insurance from ERISA's preemptive reach. Although the regulation of mixed-eligibility decisions may not appear to be traditional insurance regulation, that is because of the medical nature of the decisions. If the decisions do not fall under the purview of medical regulation because of the coverage aspect



of the decision, that cannot mean the coverage aspect is not under the purview of insurance regulation because of the medical aspect of the decision. To hold otherwise allows HMOs to evade state regulation entirely by couching their coverage decisions in terms of medical necessity. The state *amici* believe there is no evidence that Congress intended to grant HMOs this unique exemption from all state regulation.

Although Rush Prudential asserts that Illinois's independent review law is preempted as an alternate enforcement mechanism that conflicts with ERISA § 502(a), an analysis of this Court's decisions construing § 502(a) demonstrates that Congress did not intend for § 502(a) to preempt state independent review laws. If medical-necessity decisions are viewed as medical in nature and Congress did not intend for ERISA's express preemption provision to preempt state healthcare regulation, it could not have intended for § 502(a) nevertheless to preempt that very same state regulation. If these decisions are considered only coverage decisions involving payment, then independent review laws would come within ERISA's saving clause, and § 502(a) should not be construed contrary to the express language of the saving clause to preempt state insurance laws.

Finally, in any event, the concerns underlying this Court's decisions that § 502(a) preempts alternate enforcement mechanisms are not at issue in medical-necessity decisions because the very nature of these decisions involve questions of medical judgment, not plan interpretation. The questions raised are not whether a plan has chosen to cover a particular treatment. The questions are whether a covered treatment is medically necessary. These are fact-specific

questions as this Court noted in *Pegram*. Even though those fact-specific questions may be the basis of both an independent review and a § 502(a) action, that does not give rise to preemption under this Court's decision in *Lingle v. Norge Division of Magic Chef, Inc.*, 486 U.S. 133 (1988), a case underpinning this Court's alternate enforcement mechanism preemption decisions.

## ARGUMENT

The Seventh Circuit held that ERISA did not preempt § 4-10 of the Illinois HMO Act. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000). The court thought that § 4-10 could subject ERISA plans to conflicting state regulations and, therefore, had a "connection with" ERISA. *Id.* at 968. But the court held that § 4-10, as a law regulating insurance, becomes part of the insurance contract. *Id.* at 970. Additionally, because § 4-10 could only be enforced in an ERISA § 502(a) proceeding, the court held that there was no conflict. *Id.* This analysis is consistent with this Court's prior decisions, but the state *amici* think there are distinct and more fundamental reasons why § 4-10 is not preempted.

### I. This Court Should Clarify that Traditional Preemption Principles Govern ERISA Preemption Analysis.

Whether ERISA preempts § 4-10 of the Illinois HMO Act necessarily involves the text of § 514 of ERISA and its "relate to" clause. 29 U.S.C. § 1144(a). Because this clause lacks any discernable content, "ERISA preemption of state law has left courts, including the Supreme Court, deeply troubled." *Prudential Ins. Co. of Am. v. Nat'l Park Med.*



*Ctr.*, 154 F.3d 812, 815 (8th Cir. 1998). A federal judge has opined that "the words 'relate to' stretch and contract like a rubber band" as courts wrestle with the inequities of ERISA preemption. William M. Acker, Jr., *Can the Courts Rescue ERISA?*, 29 CUMB. L. REV. 285, 289 (1999). But in 1993, the Court held that "we discern no solid basis for believing that Congress, when it designed ERISA, intended to fundamentally alter traditional preemption analysis." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99 (1993). This Court should clarify that the "relate to" provision in ERISA is not a unique species of preemption peculiar to ERISA, but should be interpreted in accordance with traditional preemption principles.

Nearly six years ago, the Court held that "relate to" preemption analysis must go beyond ERISA's unhelpful text and look to "the objectives of the ERISA statute as a guide." *Travelers*, 514 U.S. at 656. This Court admonished the lower courts for interpreting ERISA § 514(a) with an "uncritical literalism" that only results in "infinite connections" that Congress did not intend. *Id.* Nevertheless, the confusion persists in the lower courts and the threat remains that the "relate to" clause will be incorrectly applied to displace state regulations Congress never intended to preempt.

Last term, Justice Scalia cautioned that the only way to give this statute a "plausible and precise content" that "would not pick up every ripple in the pond" is to interpret ERISA's "relate to" clause "as a reference to our ordinary pre-emption jurisprudence." *Egelhoff v. Egelhoff*, 121 S.Ct. 1322, 1331 (2001) (Scalia, J., concurring); *see also Dillingham*, 519 U.S. at 336 (1997) (Scalia, J., concurring).

Likewise, Justice Breyer wrote that "[l]ike Justice Scalia, I believe that we should apply normal conflict pre-emption and field pre-emption principles where, as here, a state statute covers ERISA and non-ERISA documents alike." *Egelhoff*, 121 S.Ct. at 1331 (Breyer, J., dissenting). Employing traditional preemption analysis to § 4-10 of the Illinois HMO Act would clarify this Court's past holdings and offer the lower courts much needed guidance.

This Court's past holdings examining ERISA's express preemption provision can be reconciled with traditional preemption analysis. The "relate to" clause has been construed as a two-part test, which asks whether the law: (i) expressly "refers to" or acts exclusively on ERISA plans; or (ii) has an impermissible "connection with" ERISA. *Dillingham*, 519 U.S. at 324–25. The state *amici* suggest that the "connection with" analysis be considered field preemption analysis encompassing "whether the state law intrudes into an area Congress—given ERISA's basic objectives—would have wanted to reserve exclusively for federal legislation." *Boggs*, 520 U.S. at 860 (Breyer, J., dissenting).

The areas Congress wanted to reserve exclusively for federal regulation are an employer's decision to provide benefits and a multistate employer's ability to administer and to pay for those benefits in a uniform fashion.[3] Accordingly,

[3] State laws that are dependent on the existence of an ERISA plan for an element of the state-law cause of action or expressly refer to ERISA plans can also be said to fall within the field Congress intended to preempt. *See District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988).



this Court has held that state mandated benefit laws are preempted. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985); *Shaw v. Delta Air Lines*, 463 U.S. 85, 97 (1983). In both *Shaw* and *Metropolitan Life*, however, the Court held that specific provisions in ERISA saved the state laws, *i.e.*, removed them from the field of preemption. *Shaw*, 463 U.S. at 108; *Metropolitan Life*, 471 U.S. at 746-47. The Court has also held that States cannot require multistate plans to calculate benefits in different ways.[4]

The concept of uniformity of benefits and plan administration is only relevant to multistate ERISA plans. An ERISA plan operating only within one State cannot, by definition, be subject to different state laws.[5] Also, many ERISA plans purchase insurance or use third parties to administer their self-funded plans. The fact that these insurers and third-party administrators may operate nationally and offer the same benefits and administration in different States is not,

[4] *See FMC Corp. v. Holliday*, 490 U.S. 52, 60 (1990) (Pennsylvania law could not be enforced against self-funded plans because "[i]t requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar anti-subrogation legislation."); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 14 (1987) (Maine's severance pay law was not preempted because requiring a one-time payment of a benefit did not create the potential for conflicting regulation of benefit plans); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (New Jersey law preempted by ERISA "because it eliminates one method for calculating pension benefit—integration—that is permitted by federal law").

[5] The record does not reflect whether the employer in this case was a multistate employer with a multistate ERISA plan.

however, of any consequence. As this Court recognized in *Coyne*, "ERISA's preemption provision does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit plans.'" 482 U.S. at 7. Accordingly, state laws regulating intrastate ERISA plans do not effect plan uniformity. Moreover, uniformity is only an issue in a multistate plan where the procedure effected by the state law is uniform in nature, such as a method for calculating benefits. If the plan procedure by its nature does not produce uniform results, Congress's concern with uniformity is not implicated.

Plan uniformity is also the basis of this Court's finding that state laws that provide alternate enforcement mechanisms are preempted by ERISA § 514(a). *Travelers*, 514 U.S. at 658 ("we have held that state laws providing alternate enforcement mechanisms also relate to ERISA plans, triggering preemption" (citing *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990))). In *Ingersoll-Rand*, the Court held that a wrongful discharge action under Texas law for terminating an employee to avoid paying benefits was preempted because ERISA § 510 provided an identical claim that could be enforced under § 502(a). The Court explained that the state action related to an ERISA plan because state courts might develop different substantive standards applicable to wrongful discharge actions and "[s]uch an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." 498 U.S. at 142.

Even where state laws are construed as effecting plan administration and uniformity, however, that is not the end of the inquiry. As this Court recognized, a state law that effects plan administration only because it increases costs to the plan



is insufficient to result in preemption.[6] If any law that effected plan administration was preempted, then ERISA preemption would be just as expansive as an unfettered "relate to" analysis—an analysis rejected by this Court in *Travelers*. Moreover, in areas of traditional state regulation, there must be more than simply an impact on plan administration, there must be some evidence that Congress intended to place such state laws within ERISA's preemptive reach.

When a party challenges an exercise of the States's historic police powers, then that party "bear[s] the considerable burden of overcoming 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 520 U.S. at 814 (citing *Travelers*, 514 U.S. at 654; *Dillingham*, 519 U.S. at 325). This reluctance to find preemption applies "with equal force where Congress has spoken, though ambiguously." *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 533 (1992) (Blackmun, J., concurring). Healthcare regulation is an exercise of police power traditionally left to state regulation. *Travelers*, 514 U.S. at 654-55. *See also Pegram*, 530 U.S. at 237 and *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (holding that healthcare regulation is a traditionally reserved state power).

Independent review laws, depending on how the Court interprets a mixed-eligibility decision, involve either healthcare

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[6] *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 816 (1997) ("Any state law, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is pre-empted by the federal statute.").

or insurance—both traditional areas of state regulation. Therefore, state independent review laws are presumptively not preempted absent evidence of legislative intent that preemption was the "clear and manifest purpose" of Congress. *Travelers*, 514 U.S. at 654. ERISA preemption analysis in this case must begin and end with that premise.

## II. Section 4-10 is Not Within the Field of ERISA's Express Preemption Provision and Is Within the Scope of the State Laws That Congress Understood Would Survive ERISA Preemption.

Section 4-10 addresses healthcare issues outside the field of ERISA preemption. Moreover, even if § 514(a) "connection with" analysis is given a discrete meaning, § 4-10 would likewise survive ERISA preemption because independent review laws are within "the scope of the state law that Congress understood would survive" and the "nature and effect" of independent review laws do not require preemption.[7] As this Court noted in *Pegram*, utilization review contains a medical component. 530 U.S. at 229 (a medical-necessity decision "cannot be untangled from physicians' judgments about reasonable medical treatment"). It is this medical component that the States seek to regulate.

State independent review statutes review the medical judgment exercised in a mixed-eligibility decision. The purpose of these statutes is to decide whether the HMO correctly determined the "appropriate medical response" to a

[7] *See Egelhoff*, 121 S.Ct. at 1327 (quoting *Dillingham*, 519 U.S. at 325 and *Travelers*, 514 U.S. at 656).



given "patient's constellation of symptoms." *Pegram*, 530 U.S. at 228. The issue is what medical response a patient's condition necessitates. Even though treatment and coverage become inextricably mixed because of the nature of managed care, that does not change the medical nature of the decision.

Independent review statutes address the central issue of healthcare regulation—is medical treatment necessary? If Congress did not intend to impose ERISA fiduciary obligations on HMOs for medical-necessity decisions, *see Pegram*, 530 U.S. at 231, then there is no reason to think, nor is there any legislative history to show, that Congress nevertheless intended ERISA to preempt the States's regulation of medical-necessity decisions. Although not explicitly decided in *Pegram*, the Court's analysis in *Pegram* indicates that a mixed-eligibility decision made by a treating physician is not within the field of ERISA preemption. The question then arises, are mixed-eligibility decisions made by an HMO within the field of ERISA preemption?

When a medical director of an HMO makes a mixed-eligibility decision, can a state discipline that physician when the exercise of that medical judgment does not comply with the state standard of medical care? The state *amici* believe the answer is yes, as does the Missouri Supreme Court,[8] because

[8] "The determinations at issue in this case fall outside the scope of plan administration. Dr. Fallon did not simply look to a predetermined list of covered procedures to arrive at his conclusions. He used medical training and judgment to make a decision about the 'medical necessity' of surgical treatment for a particular patient. This medical judgment is analytically distinct from the coverage policies adopted by the employee benefit plan. Though the choice to cover a patient's expenses is an administrative

the only issue being addressed is whether the appropriate medical standards were used. Although the review of a medical-necessity decision by a medical review board can be distinguished from the independent review of that decision, at their heart, both involve a review of the medical judgment exercised by a physician—a role historically left to the States.

HMOs may claim that there is a distinction between a treating physician making a mixed-eligibility decision and an HMO making a mixed-eligibility decision, but that is a distinction without a practical difference, at least with respect to review of prospective and concurrent mixed-eligibility decisions. Whether it is the treating physician or the HMO deciding that treatment is not medically necessary, the result is the same. The patient will likely not receive medical care. J. Scott Andresen, *Is Utilization Review the Practice of Medicine?, Implications for Managed Care Administrators*, 19 J. LEGAL MED. 431, 434 (Sept. 1998).

While it is true that this case involves retrospective review for reimbursement, not concurrent or prospective review effecting patient care,[9] that does not render the medical

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choice, a physician's finding of 'medical necessity is purely a medical decision. . . . Whether such medical judgment is exercised by a physician providing direct treatment or by a physician during utilization review is merely coincidental to the Board's review power." *State Bd. for the Healing Arts v. Fallon*, 41 S.W.3d 474, 477 (Mo. 2001), *cert. denied*, 70 U.S.L.W. 3129 (U.S.Mo. Oct. 29, 2001)(No. 01-241).

[9] Illinois's statute provides retrospective review for denial of payment based on the medical necessity of a physician's treatment decision. Other States, such as Texas, have enacted statutes that only provide prospective



component of a mixed-eligibility decision any less a question of the exercise of medical judgment. That in this case Illinois chose to regulate the exercise of that medical judgment through an independent review should not strip Illinois of its authority merely because a plan chose to define coverage in medical terms. There is no evidence that Congress intended this and state regulation of medical-necessity decisions should thus be considered outside the scope of ERISA preemption.

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or concurrent review. *See, e.g.*, TEX. INS. CODE art. 21.58A. Indeed, Texas's petition for review is still pending before this Court. *See Corp. Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, *reh'g en banc denied*, 220 F.3d 641 (5th Cir. 2000), *petition for cert. filed sub nom Montemayor v. Corporate Health Ins., Inc.*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2001) (No. 00-665). In *Corporate Health*, Texas seeks reversal of the Fifth Circuit's judgment, which held that Texas's independent review statute is preempted by ERISA. If the Court affirms the Seventh Circuit's judgment in *Moran*, it should grant Texas's petition for certiorari in *Corporate Health* and reverse the Fifth Circuit's judgment, since the Fifth Circuit's ERISA preemption analysis conflicts with *Moran*. *See Moran*, 230 F.3d at 973 (Posner, J. dissenting) (noting the "square conflict"). At a minimum, the Court should grant Texas's petition, vacate the Fifth Circuit's judgment, and remand for reconsideration in light of this Court' s decision in *Moran*.

Moreover, the Court should grant Texas's petition even if it reverses *Moran*, because Texas's statute can survive ERISA preemption even if the Court determines that Illinois's statute cannot. The state *amici* believe that neither statute is preempted by ERISA, but if the Court disagrees as to the Illinois provision at issue in *Moran*, that holding would not necessarily apply to other state independent review provisions—like Texas's—that provide for only prospective or concurrent review. That distinct issue can be squarely resolved by granting Texas's petition for review in *Corporate Health*.

Moreover, HMO complaints that independent review laws interfere with plan administration are overwrought. An ERISA plan is free to include any benefits or exclude any benefits it desires. Section 4-10 only operates once a plan has determined what benefits it will provide and then only when a plan defines its payment obligations in medical terms.

Rush Prudential also heralds uniformity as a reason for allowing it to avoid state regulation of its medical-necessity decisions and such purported uniformity is the basis for claiming § 4-10 relates to an ERISA plan as an alternate enforcement mechanism. *See Ingersoll-Rand*, 498 U.S. at 142. But every medical-necessity decision is, by definition, devoid of uniformity since it is particular to the patient whose health is at issue. As this Court has recognized:

> [a]lthough coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in *particular* cases. The issue may be, say, whether one treatment option is so superior to another *under the circumstances*, and needed so promptly, that a decision to proceed with it would meet the medical necessity requirement that conditions the HMO's obligation to provide or pay for that *particular* procedure at that time.

*Pegram*, 530 U.S. at 228–29 (emphasis added).

While at first blush retrospective independent review laws appear to govern the payment of benefits, that is incidental to the review of the exercise of medical judgment inherent when a plan conditions payment for coverage in terms



of medical necessity. Unlike a situation in which a state law dictates who a beneficiary is, or requires payment contrary to the terms of plan documents,[10] independent review laws review an HMO's exercise of medical judgment, not an HMO's interpretation of plan documents. Every time an HMO determines whether a physician's recommended treatment is medically necessary, it is making a unique decision based on the specific symptoms of a specific patient. These decisions, by definition, are made on a case-by-case basis, not by reference to plan documents, but by reference to the beneficiary's medical condition. Rush Prudential's argument that Illinois's independent review law is preempted because it interferes with plan administration is, therefore, inapposite in the medical-necessity context, because medical judgment, not plan interpretation, is in question and "uniformity" is a practical impossibility.

## III. Congress Expressly Intended State Insurance Laws, Like § 4-10, to Survive Preemption Analysis.

If mixed-eligibility decisions, despite the fundamental medical nature of the decisions, are considered coverage decisions, then laws regulating the making of these coverage decisions by HMOs should be considered insurance laws expressly saved from preemption. Indeed, because of the mixed nature of the decisions, it is conceivable that a mixed-eligibility decision can be construed as both an exercise of medical judgment that implicates state healthcare regulation

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[10] *See, Egelhoff*, 121 S.Ct. at 1327 ("the administrators must pay benefits to the beneficiaries chosen by state law, rather than those identified in plan documents.")

and a coverage issue of payment that implicates traditional insurance regulation. Although the Fifth Circuit differed from the Seventh Circuit on the whether ERISA § 502(a) requires preemption of independent review laws, both circuit courts had no difficulty concluding that independent review laws were laws regulating insurance within the ambit of ERISA's saving clause because they met the common-sense definition of insurance and at least two of the three McCarran-Ferguson Act factors. *Moran*, 230 F.3d at 969; *Corporate Health*, 215 F.3d at 538.

The Fifth Circuit's reasoning that independent review laws are laws regulating insurance is telling:

> Independent review provisions create a regulatory scheme governing health benefit determinations. They do not rely on general legal rights used in other areas of law. That the provisions apply to managed care entities as well as to traditional insurers does not exclude them from the saving clause. . . . In making benefit determinations, these entities are functioning as insurers.

*Corporate Health*, 215 F.3d at 538 (internal citations omitted). Independent review laws also "go to the core of the insured-insurer relationship" because they "create a procedural right of the insured against the entity" and accordingly "they meet the common sense test of the saving clause." *Id.*; *accord Moran*, 230 F.3d at 969-70. "For the same reasons, the provisions satisfy the second and third prongs of the McCarran-Ferguson test: they are integral to the policy relationship and regulate the insurance industry." *Corporate Health*, 215 F.3d at 538. Accordingly, "Section 4-10 clearly



satisfies the second and third McCarran-Ferguson factors." *Moran*, 230 F.3d at 970. Although both circuits found it unnecessary to find that the first McCarran Ferguson factor was met—the spreading of risk—§ 4-10 does meet this factor. Independent review laws spread risk by requiring the equivalent of a binding arbitration mechanism to determine which risks will be spread between the HMO and the enrollee needing medical care. Risk is spread by effectuating the terms of the insurance contract, without which there would be no risk transfer at all. *U.S. Dept. of Treasury v. Fabe*, 508 U.S. 491, 504 (1993).

The Fifth and the Seventh Circuits correctly held that independent review laws are laws regulating insurance within the meaning of ERISA's saving clause. Those courts disagreed, however, on whether a saved state independent review law is nevertheless preempted by §502(a). The Seventh Circuit reasoned that a claim to enforce the independent review decision "cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a)," because they are "not tantamount to the relief offered under § 502(a)(1)(B)." *Moran*, 230 F.3d at 971. Rather, independent review "simply adds to the contract, by operation of law, an additional dispute resolving mechanism." *Id.* at 972. The Seventh Circuit recharacterized Moran's claim as a benefits claim under ERISA §502(a) and distinguished *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). *Id.* (citing *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375-76 (1999)). By recharacterizing the claim, the court determined that *Pilot Life* did not require preemption. *Id.* Thus, the Seventh Circuit held the Illinois independent review law provided the rule of decision in Moran's ERISA §502(a)

claim for reimbursement. *Id.* This analysis is consistent with this Court's decision in *Ward*.[11]

Although the state *amici* concur in the Seventh Circuit's reasoning and result, there is an additional, and more fundamental, reason why § 502(a) cannot preempt a saved state insurance law. When Congress has spoken, the "task is to identify the domain expressly pre-empted, because 'an express definition of the pre-emptive reach of a statute . . . supports a reasonable inference . . . that Congress did not intend to pre-empt other matters." *Lorillard Tobacco Co. v. Reilly*, 121 S.Ct. 2404, 2414 (2001) (internal citations omitted). Application of this principle to ERISA confirms that § 4-10 of the Illinois HMO Act is expressly "saved" because it is a law regulating insurance.

Section 514(a) of ERISA provides, in pertinent part, that: "Except as provided in subsection (b) of this section, ... this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In subsection (b), Congress expressly saves from preemption "any law of any State which regulates insurance." *Id.* § 1144(b)(2)(A). This Court has recognized that:

[11] The saving clause incorporates state law into the plan providing benefits, i.e., the mandated benefit law in *Metropolitan Life* and the notice-prejudice rule in *Ward*. Independent review provisions are incorporated into ERISA plans and supply the relevant rule of decision in a §502(a) suit. Thus, to the extent the independent review is relied upon in a §502(a) enforcement action, under *Ward*, it is not preempted.



> The ERISA saving clause, with its similarly worded protection of "any law of any State which regulates insurance," appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States.

*Metropolitan Life*, 471 U.S. at 744 n.21.[12] Thus, "[i]f a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *Holliday*, 498 U.S. at 64.

Illinois's independent review statute regulates insurance; therefore, pursuant to the saving clause, it is not preempted by ERISA. Rush Prudential erroneously argues, however, that §4-10 is nevertheless preempted because under *Pilot Life*, § 502(a) trumps the saving clause. The Court should reject Rush Prudential's sweeping reading of *Pilot Life*, because that case did not involve a state law regulating insurance and did not address the plain meaning of the saving clause.

[12] Promptly after this Court held in *U.S. v. South-East Underwriters*, 322 U.S. 533 (1944), that insurance was interstate commerce, Congress passed the McCarran-Ferguson Act to return insurance regulation to the States. *See Fabe*, 508 U.S. 491 (1993). Since then, the business of insurance has been subject to state regulation. Federal deference to state regulation of insurance is so strong that it extends to an exemption found in the Bankruptcy Code. *See* 11 U.S.C. § 109(b)(2).

The plaintiff in *Pilot Life* sought extra-contractual damages for emotional distress and punitive and exemplary damages under Mississippi common law for failure to pay a claim. *Pilot Life*, 481 U.S. at 43. After finding that the cause related to ERISA, this Court held that Mississippi's common law tort of bad faith extended to "[a]ny breach of contract and not merely breach of an insurance contract:" *Id.* at 50. Thus, the law could not be considered an insurance law subject to ERISA's saving clause. *Id.* Consequently, *Pilot Life*'s exclusive-remedy discussion has no application to state insurance laws, because no such laws were before the Court. Indeed, the Court recognized this in *Ward*, 526 U.S. at 376 n.7. *Ward* observed that *Pilot Life* must be read in the context of a "law not specifically directed to the insurance industry and therefore not saved from ERISA pre-emption."[13] *Ward* forecloses Rush Prudential's argument that *Pilot Life* requires preemption of Illinois's independent review statute.

The plain meaning of the saving clause reflects Congress's express rejection of Rush Prudential's argument that § 502(a) preempts Illinois's independent review statute. Congress stated that "*nothing in this subchapter* shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). The saving clause and § 502(a) are in the same part, the same subtitle, and the same subchapter of ERISA. It is inconceivable that Congress intended the saving

[13] *Id.* The Court also noted that the Solicitor General's brief asserted that "the insurance saving clause . . . saves state law conferring causes of action or affecting remedies" and that reliance on *Pilot Life* for a contrary result was without merit. *Id.*



clause to have no effect on laws implicating § 502(a). To the contrary, the text of ERISA demonstrates Congress's intent to create an exception from preemption for state insurance laws.

The Court's construing the saving clause as excluding insurance remedies from § 502(a) preemption would also be consistent with the Court's decision in *John Hancock*. 510 U.S. at 86. In *John Hancock*, the plaintiff asserted that ERISA's requirement that a fiduciary act "*solely* in the interest of . . . participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits," must yield to conflicting state-law requirements that an insurer managing general account assets consider the interests of, and maintain equity among, all of its contractholders, creditors, and shareholders. *Id.* at 97 (contrasting 29 U.S.C. § 1104(a) and N.Y. [INS.] LAW § 4224(a)(1)). The Court noted that "[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself." 510 U.S. at 99 n.9 (citations omitted). Here, § 4-10 does not supercede a provision of ERISA, it complements one. The Court recognizes that complementary, dual regulation is permitted under ERISA. *Id.* at 100. To hold otherwise "would virtually read the saving clause out of ERISA." *Ward*, 526 U.S. at 376.

Independent review statutes, such as § 4-10 of the Illinois HMO Act, survive ERISA preemption because they complement ERISA. Insurance regulation serves one basic purpose—to ensure that promised benefits are provided when needed. This is done through regulation of solvency and regulation of claims practices to insure that claims can and will be paid. *See Metropolitan Life*, 471 U.S. at 729 n.2. It would defeat a fundamental purpose of state insurance law to accept

Rush Prudential's argument that any state insurance law that has the effect of requiring payment of a claim cannot be saved from preemption. Although subsection (a) of ERISA's express preemption provision is not a model of clarity, subsection (b) is. Congress explicitly excluded state insurance laws from ERISA preemption and this intent should be given effect by finding that a state independent review law such as § 4-10 is saved from preemption.

## IV. Section 4-10 Does Not Conflict With ERISA.

State statutes providing independent review of the medical necessity of physicians's treatment decisions do not conflict with ERISA whether they are treated as saved insurance laws or state regulation of medical necessity that Congress did not intend for § 514(a) to preempt. Traditional conflict preemption principles require conflict preemption of state law only "to the extent it actually conflicts with federal law, that is, when it is impossible to comply with both state and federal law, or where the state law stands as an obstacle to the accomplishments of the full purposes and objectives of Congress." *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (citations omitted); *accord Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 98 (1992). A conclusion that Congress intended to preempt independent review laws requires finding that Congress "has left no room" for state regulation or that the federal interest requires that the federal system dominate state laws of the same subject. *Hillsborough County v. Automated Med. Lab., Inc.*, 471 U.S. 707 (1985).

No substantive provision in ERISA governs the provision of medically-necessary care to participants or beneficiaries. Accordingly, there is no direct conflict.



Moreover, these independent review statutes, far from standing as an obstacle to ERISA's objectives, actually further the protection of plan participants and beneficiaries by providing a check on an HMO's incentive to provide less care than a plan participant or beneficiary needs. *See Pegram*, 530 U.S. at 218–20 (discussing the structure of HMOs and their cost-controlling measures).

ERISA's principal objective is to protect plan participants and beneficiaries. *See, e.g., Boggs*, 520 U.S. at 845 (quoting *Shaw*, 463 U.S. at 90 ("ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries.")). The text of ERISA states that its policy is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). Similarly, the purpose of independent review statutes is to protect the quality of HMO participants's healthcare. *External Review Update*, *supra* n.2 at 1. Importantly, they impose a measure of accountability on HMOs.[14] Rather than standing as an obstacle to congressional intent, state independent review statutes actually further ERISA's primary purpose.

Specifically, there is no conflict with § 503 of ERISA, which provides that participants are entitled to "a full and fair review by the appropriate named fiduciary" of a benefit denial under "regulations of the Secretary [of the Treasury]." 29

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[14] *See* The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Quality First: Better Health Care for All Americans, Final Report to the President of the United States* (1998).

U.S.C. § 1133(2). This internal, administrative review is not the independent, external review contemplated by § 4-10 and thus the Illinois statute "complements rather than contradicts ERISA and the regulation." *Ward*, 526 U.S. at 377. Moreover, HMOs could comply with both regulations. Since this Court holds that "ERISA leaves room for complementary or dual federal and state regulation," there is no preemption of § 4-10 of the Illinois HMO Act due to a direct conflict. *John Hancock*, 510 U.S. at 98.

Nor does § 4-10 conflict with ERISA § 502(a). Rush Prudential maintains there is a conflict relying on *Pilot Life*, and arguing that Congress intended to preempt all civil remedies. First, the state *amici* contend that Congress would not have intended to preempt an independent review law under § 502(a) that is not preempted by ERISA's express preemption clause. *See supra*, Parts II and III. Second, Rush Prudential misconstrues this Court's holding in *Pilot Life*.

This Court's analysis in *Pilot Life* was informed by the decision in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985).[15] In *Russell*, this Court held that Congress did not intend to allow the federal judiciary to imply a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims. *Id.* at

[15] *Russell* concerned a claim that an insurance company administering an ERISA plan breached its fiduciary duty under ERISA by failing to promptly process the ERISA beneficiary's claim for disability benefits. The Ninth Circuit held the insurer's actions violated ERISA fiduciary duties giving rise to a federal cause of action that included compensatory damages for mental or emotional distress and punitive damages against the fiduciary. *Russell*, 473 U.S. at 138.



148. Similarly, *Pilot Life* concerned a state-law cause of action for extra-contractual damages against an ERISA plan for failure to pay benefits. The claims in *Pilot Life* were tortious breach of contract, breach of fiduciary duties, and fraud in the inducement. The plaintiff was seeking damages for failure to pay benefits, general damages for mental and emotional distress, other incidental damages, and punitive and exemplary damages. This Court held that the federal remedy provided in ERISA § 502(a) displaced these state causes of action. *Pilot Life*, 481 U.S. at 57; *see also Ingersoll-Rand*, 498 U.S. at 486 (holding that a state cause of action for wrongful discharge that duplicated a cause of action under § 502(a) for violating ERISA § 510 was preempted). Unlike the statutes in *Pilot Life* and *Russell*, however, the independent review laws do not provide a cause for action for extra-contractual damages. Nor does § 4-10 provide for any state cause of action as was the case in *Pilot Life* and *Ingersoll-Rand*. These cases, therefore, are not controlling here.

In *Pilot Life*, the Court analogized § 502(a) of ERISA to § 301 of the Labor Management Relations Act of 1942, 29 U.S.C. §§ 141–187 (LMRA).[16] The Court reasoned[17] that since the LMRA provides federalized remedies for violation of

[16] *Pilot Life*, 481 U.S. at 56 (citing 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA, 94th Cong., 2d Sess., 2359 (Comm. Print 1976)("All such actions in Federal or State Court are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the [LMRA].").

[17] The Court was influenced by the brief of the United States advocating that § 502(a) be considered an exclusive remedy. The Solicitor General subsequently repudiated that analysis in *Ward*, 526 U.S. at 376 n.7.

collective bargaining agreements, so too should ERISA. In *Ingersoll-Rand*, the Court noted the parallel between § 502(a) and § 301, and held that a state cause of action was preempted because it purported "to provide a remedy for a violation of a right expressly guaranteed by § 510 and exclusively enforced by § 502(a)." *Ingersoll-Rand*, 498 U.S. at 145 (citing *Magic Chef*, 486 U.S. at 409 n.8). A closer examination of *Ingersoll-Rand*, the LMRA and the *Magic Chef* decision, however, reveals the flaw in Rush Prudential's argument that § 502(a) preempts § 4-10.

First, in *Ingersoll-Rand*, the state claim duplicated an express right guaranteed in ERISA. There is, however, no right to an independent review in ERISA. Accordingly, §4-10 does not duplicate an ERISA right and concomitant remedy and thus there is no conflict preemption.

Second, a holding that § 4-10 is preempted by § 502(a) would not comport with Congress's intent, as it thwarts Congress's fundamental purpose in enacting ERISA. The necessity for uniform interpretation of collective bargaining agreements provides the foundation for this Court's determination that the LMRA provides exclusive remedies. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 25 n.28 (1983). Congress's principal purpose in enacting ERISA was "to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator." *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989). ERISA's stated purpose is "to protect . . . the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b). Accordingly,



interpreting ERISA as synonymous with the LMRA to frustrate the legitimate expectations of beneficiaries to receive necessary medical care does not comport with congressional intent.

Third, even if § 502(a) was patterned after the LMRA, this Court has held that state law claims that do not require interpretation of collective bargaining agreements are not preempted under the LMRA. *Magic Chef*, 498 U.S. at 409–10 (state tort suit for retaliatory discharge was not preempted because "even if dispute resolution pursuant to a collective-bargaining agreement, on the one hand, and state law, on the other, would require addressing precisely the same set of facts, as long as the state-law claim can be resolved without interpreting the agreement itself, the claim is 'independent' of the agreement for § 301 pre-emption purposes"). A similar analysis of independent review laws reveals they should likewise be considered independent of an ERISA plan document for § 502(a) preemption purposes.

Independent review laws do not require interpretation of benefit plans, nor do they result in the development of differing substantive law standards applicable to ERISA plans. The issues are unique questions of medical necessity rather than plan interpretation and, thus, the concerns expressed in *Ingersoll-Rand* are not at issue. Instead, the *Magic Chef* case is more on point and § 4-10 does not run afoul of any exclusive enforcement concerns underlying this Court's decisions, even though the same set of facts may be the basis for both an independent review and a § 502(a) action.

Moreover, medical decisionmaking becomes an issue in both an independent review and a § 502(a) action only

because plans couch their coverage in terms of medical necessity. A plan cannot create ERISA preemption, however, by clever draftsmanship of a plan. Medical necessity is a question of what the "appropriate medical response" to a given "patient's constellation of symptoms." *Pegram*, 530 U.S. at 228. That appropriate medical response is not dependent on the language in a plan document, it is dependent on medical judgment. Accordingly, Rush Prudential's arguments that § 4-10 conflicts with ERISA should be rejected.

## CONCLUSION

The Court should affirm the judgment of the Seventh Circuit.

Respectfully submitted,

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